UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF WASHINGTON AT SEATTLE

N.C., individually and on behalf of A.C., a minor, Plaintiffs, v. PREMERA BLUE CROSS, Defendant.	C21-01257-JHC SEATTLE, WASHINGTON October 24, 2022 9:00 a.m. Motion Hearing

VERBATIM REPORT OF PROCEEDINGS
BEFORE THE HONORABLE JOHN H. CHUN
UNITED STATES DISTRICT JUDGE

APPEARANCES:

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THE CLERK: This is case No. C21-1257. N.C. versus Premera Blue Cross. Counsel, please rise and make your appearances for the record.

MR. KING: Brian King and Ellie Hamburger for the plaintiff.

MS. PAYTON: I'm Gwendolyn Payton, for Premera Blue Cross. Along with me is Melissa Anderson, from Premera Blue Cross.

THE COURT: Okay. Let me just get set up here.

Each side has 20 minutes for oral argument. I may follow up with additional questions.

Mr. King, you're up first. Would you like to reserve any time for rebuttal?

MR. KING: Yes, Your Honor. Five minutes is fine.

THE COURT: Okay. Go ahead.

MR. KING: Good morning, Your Honor. Pleased to be with you in person here in Seattle.

As you know, this involves a young -- an individual who was adopted at a very early age, and had some significant mental health issues. The threshold issue before the court is the standard of review; and that is something that I think the parties are in pretty good agreement on. I'll certainly not commit Premera to their position here.

THE COURT: When you raised it, it was de novo. It seemed they didn't really respond to that.

MR. KING: The thing I think the parties agree -- it is de novo -- is that this is a fully insured plan. And ERISA plans that are fully insured, are subject to state insurance law. And state insurance law here in the State of Washington is quite clear, in saying that discretionary authority clauses are banned, and therefore the courts are required to give de novo consideration to these cases.

Another important issue, we think, and I think we probably have a little more disagreement on this point, is what the scope of review is. Our position is that the scope of review, Your Honor, is limited to the pre-litigation appeal record. And that information, specifically reasons for denial that were not raised by Premera during that pre-litigation appeal process, are not something that are available to be raised here.

The body of law that deals with the need for exhaustion of remedies and for a thorough, adequate, pre-litigation appeal record to be developed for this court to review, as opposed to being the initial fact finder, is extensive, both in the Ninth Circuit and across the country. And it applies here.

We have a situation where this individual was covered by the plan from June 18th through -- the treatment, rather, was provided at Change Academy Lakes of the Ozarks, which I will call CALO, from June 18, 2019, through sometime in July, I believe, in 2020. The patient was seen by Dr. Neer, who was

an MD at CALO. The pre-litigation process, there was a denial letter in September of 2019. There was an appeal to that denial, in February 2020. That appeal letter contained a number of letters of medical necessity from various individuals, who were treating clinicians of the child.

Then there was a denial letter relying on an AllMed review, an external reviewer, in July of 2020, from Premera. And that review relied on an AllMed external reviewer. And there was a great deal of acute symptomology language in that letter. And that gives rise to a number of the arguments that we have here today.

The second-level appeal from the family was in August of 2020. And then there was a final denial letter, Your Honor, in September of 2020, in which the reviewer indicated that the reason for denial -- there were like two or three reasons, but one of the primary reasons was that the child did not have active plans to end his life, or others'.

What we have here is several problems, as to both causes of action. We have two causes of action, Your Honor. One is the wrongful denial of benefits; and then the second is the mental health parity claim. I'll talk about the wrongful denial of benefits action first.

We contend, as we outlined, and I think most specifically and clearly it's outlined in the opposition memo, Your Honor, on Page 5, that the claim was wrongfully denied, for a number

of reasons. First, it ignores the requirements of the medical necessity that are outlined in the policy itself. What you've got is the InterQual medical necessity criteria. But they have to yield to the language, the unambiguous language of the plan document itself.

THE COURT: So let me ask you a question about that. Pointing to the unambiguous language in the plan, the plan ties medical necessity to generally accepted standards of medical practice. Premera's position is they relied on InterQual, which is generally accepted. What do you think I should apply here, since it's a de novo review?

MR. KING: Well, we don't have a problem if you apply the generally accepted standards of medical practice.

THE COURT: Which ones?

MR. KING: Well, I don't have a problem, necessarily, applying the InterQual criteria. Because the InterQual criteria, at times, we believe, are somewhat deviant from generally accepted standards of medical practice. But I don't think it's necessary for the court to get into the details of that, for this reason.

The actual criteria that's applied by Premera in denying the claim is so at odds with both the standards of InterQual and the generally accepted standards of medical practice language that's in the plan, I think you're going to find that under de novo standard of review, there was a

significant deviation in the sense that Premera's reviewers specifically talk about acute medical necessity criteria, in a way that neither the language of the plan nor InterQual allow.

THE COURT: But if it's de novo review, though, doesn't it mean I look at it anew? If it were an abuse of discretion, of course, I would be taking a look at what they did. But if it's de novo review, I'm the fact finder here, right?

MR. KING: That's a great question. And courts across the country have struggled with that. What does de novo review mean? Is what you're asking me. And I think what we can say is, most courts say you're still reviewing a pre-litigation appeal record. In other words, de novo review, to get back to the scope of review we just talked about before, doesn't require the court to go beyond the reasons for denial of the claim that were outlined by Premera.

Obviously, de novo review means you don't confer -- you don't defer, to any degree, to what Premera said. And, of course, that's a big difference between standard, the standard of review under abuse of discretion, and de novo. But you're still bound by the pre-litigation appeal record.

So I am comfortable with the court saying: Look, the language of the plan is what dictates here. Generally

accepted standards of medical practice dictate. And specifically for purposes of this case, Your Honor, the thing that allows you to, I think, feel comfortable in saying that the denial is unjustified is that, especially as you get further down the road, and the scope of the issues that Premera is relying on to deny the claim narrows, you're seeing that there's more and more talk about -- oddly enough, there's more and more talk about acute symptomology, and the need -- the absence of the child's medical records of acute symptomology.

THE COURT: Are you talking about acute symptomology versus intensity of service?

MR. KING: No. Intensity of service is the kind of services that were provided at CALO. I'm talking about Premera requiring the child to be sicker than the child actually was, in order to qualify for benefits.

THE COURT: Well, I guess I'd like you to explain for me how he qualifies under InterQual. And also I'm curious as to whether he qualifies under any other standards, for example, *Milliman*, or the *Wit*-case approach that you advanced in the *Todd R.* case.

MR. KING: Well, the *Wit* case, as you know, arose out of the Northern District of California. It's on appeal now before the Ninth Circuit. The Ninth Circuit issued a panel opinion reversing *Wit*. But there was an en banc petition

filed, and that's now under review.

One of the things that came out of *Wit*, on the part of United, who was the defendant in *Wit*, was they knew the level of criteria, called CASII, Child and Adolescent Service Intensity Instrument, I think is what CASII stands for. Whether you use CASII, InterQual or Milliman, one of the things that's critical is that subacute treatment be evaluated for subacute symptomology, as opposed to imposing on some future requirement of acute symptomology.

So what we would say is, I think that the InterQual criteria -- and we could go through that -- makes it clear that there are a variety of things that need to happen. The child needs to be sufficiently ill, to require inpatient care at all. But it also can't be a situation where the child is so sick, such as acutely and actively suicidal or homicidal, actively psychotic, unable to care for their basic needs. Those are the kinds of things that require acute inpatient treatment, as opposed to, you have to be able to cooperate in your treatment.

In that sense, Your Honor, there's a bit of a blending here that's interesting, and I think instructive for the court, in the mental health parity analysis for skilled nursing facilities. Because one of the things you see with skilled nursing is that the patient has to be able to be involved in and participating in their treatment. And what

you see, on the other hand, when you're talking about the requirement of the acuity of symptomology for this particular situation in a residential treatment center, is that they have to be so ill they can't carry out many of the daily activities of daily living, the ADLs. Or they have to be acutely suicidal or homicidal.

The last letter sent talked about there has to be very serious psychiatric symptoms, and there has to be active plans to end your life, or others'. Well, if you have that level of severity of illness, you would undoubtedly need acute inpatient hospitalization, as opposed to residential treatment. So we're talking about a continuum of care, a continuum of symptomology.

THE COURT: So would you agree, though, if I find in your client's favor of a denial of benefits claim, I'd need to hang my a hat on some generally accepted standards. So I'm asking you --

MR. KING: Yes.

THE COURT: -- which should I apply?

MR. KING: I think that you can apply -- first and foremost, the guiding principle the court should look to is the language of the plan.

THE COURT: Right. But the plan references generally accepted standards.

MR. KING: Right. And I think that the CASII

guidelines that are currently used and that were developed, arising out of *Wit*, to address Judge Spero's concerns in *Wit* are good criteria.

THE COURT: Are those comprehensively laid out in the *Wit* opinion?

MR. KING: No. CASII is the acronym. And if you -- I think that's the most recent, the most up-to-date, generally accepted standards of medical practice, or talking about what's medically necessary, and what's not, when you're talking about individuals who are being either acutely inpatient hospitalized, or residential treatment, or being treated on an outpatient basis.

But look, Your Honor, I'm not stuck on CASII. I think Milliman or InterQual --

THE COURT: If I want to go with Milliman, where do I look?

MR. KING: If you look up Milliman Care Guidelines, or MCG, you'll find them, no problem. They're publicly available.

THE COURT: And even though they're publicly available, if they're not part of the record, can I still look to them?

MR. KING: I think you can. You can take judicial notice of them, in that they've been referred to in many other cases. InterQual has been referred to in a number of

cases, of course. And they've been criticized at times. But I think that the most up-to-date, most credible standards of generally accepted standards of medical practice, are the CASII guidelines. United ended up developing them, in light of the *Wit* decision. And they live by them today. United is --

THE COURT: You've got less than three minutes; I'm curious about this Parity Act claim.

MR. KING: Yes. Thank you. Well, I mentioned, Your Honor, that's where the two come together a little bit, these arguments, because for both the wrongfully denied benefits claim and the parity argument, what we're talking about is a more limiting group of requirements by the plan, to qualify for benefits for this residential treatment, than for medical-surgical treatment for the parity analysis.

I think the best analysis we've got, and we talk about it in both our opposition and reply memo, Your Honor, but I'm looking at pages 22 and 23 of our opposition memo. There are three particular things, particularly in regard to skilled nursing facilities that we talk about, that are compared to residential treatment centers, which are quite a bit more restrictive and limiting, in terms of the availability of benefits.

That's the heart of a MHPAEA analysis, is there a disparity between the degree to which you provide benefits

for mental health and substance use disorders for a certain level of care, compared to the analogous medical care for medical and surgical treatment. And we think those things we talk about on 22 and 23, are quite relevant and clear in showing a significant disparity.

There's another disparity we point out, too, in regard to inpatient hospice care and residential treatment care. I know that Premera does not want to accede -- agree to the idea that there is any sort of comparison there. Because obviously inpatient hospice deals with end-of-life.

But what you're talking about is the analysis the court is required to carry out, under the final rules of the mental health parity statute. And that basically says what we're discussing here is a comparison of out-of-network inpatient benefits for mental health and substance use disorders, versus out-of-network inpatient benefits for medical and surgical treatment.

I don't have any dispute that the quality of care is different, that the end in mind is different. But for purposes of an appeal analysis, it's quite clear this court has to find that inpatient hospice falls somewhere on that spectrum of six items, and be compared -- a comparator. The way we think it compares favorably for us is to say, there's no criteria at all under the Premera plan for how you determine medical necessity of inpatient hospice, where there

is, as the court knows, criteria for residential treatment.

We've cited a couple of cases for you, Your Honor, the *MS* case, I think is the most prominent one, that says that this is an appropriate comparator. And, in fact, *MS* dealt with Premera and found, as we're asking this court to find, that there was a violation of the mental health parity statute, based on that inpatient hospice difference.

THE COURT: Do you know whether Premera uses the InterQual criteria to determine medical necessity in the inpatient hospice context?

MR. KING: I do not, no, Your Honor. I doubt it. I can't say that. I'm just not sure, to the extent InterQual -- you know, I'm familiar with InterQual on the mental health and substance use disorder benefit side, not so much on the medical-surgical side. But my understanding is that Premera has admitted in this litigation that they do not use InterQual in this particular policy for inpatient hospice.

THE COURT: Okay. You're out of time. I do have a couple follow-up questions, first. Do you agree, to find a Parity Act violation, we have to find medical necessity?

MR. KING: Well, I certainly think that medical necessity is a prerequisite to finding benefits available. I think you can find -- I don't think that you're precluded, Your Honor, from making a finding and a conclusion of law, a declaration, basically, that even setting aside medical

necessity, the mental health parity statute has been violated here.

Now, what the remedy is, I think is what you're getting at when you ask me that question. What's the proper remedy? That's a fair question.

THE COURT: What is the proper remedy?

MR. KING: I think the fair remedy is that if we win on the A(1)(b) claim, I'm not looking for any particular relief under the mental health parity claim. But I do think it would be extraordinarily helpful to have this court, as a matter of finding of fact, conclusion of law, state that there has been a violation of the mental health parity statute. And you see, in fact, Judge Parrish, in the *Jonathan Z.* case, doing exactly that.

THE COURT: What type of remedy is that? Is that declaratory relief?

MR. KING: Yes. And as we develop this area of law, as you know, Your Honor, the mental health parity statute is relatively new, it's developing, it's evolving. I think what we're looking for is courts talking about and identifying, in a way that's helpful for their sister courts down the road, well, was this a violation of the mental health parity statute, or not? I don't know that the remedy is going to be that important, simply because the remedy turns on the individual facts and circumstances of the case.

THE COURT: If you prevail on the Parity Act claim, is there a fee shifter?

MR. KING: Well, there is. It's the same fee shifting structure that ERISA itself has.

THE COURT: Thank you. You'll have five minutes for rebuttal.

MR. KING: Thank you.

MS. PAYTON: Thank you, Your Honor. I might as well -- Gwendolyn Payton for Premera -- pick up where that conversation was.

If the plaintiff doesn't have standing because the plaintiff has not been harmed, the plaintiff doesn't have standing to bring -- to have a remedy under the Parity Act. And the claim just fails, because harm is an essential element of the claim.

I want to go back and talk about the thing that was really fascinating in your conversation with Mr. King, is, can you look at guidelines that are outside of the administrative record that are in front of you under de novo review? And I agree, you should review this claim de novo. I've never seen a court do that, other than when the court has found that the criteria that the plan applied was incorrect. And that would be like the *Wit* case. And by the way, I think you know this, Your Honor, *Wit* was overturned by the Ninth Circuit. And so relying on that district court opinion would probably be a

dangerous thing to do at this point.

THE COURT: Does it matter on what grounds they were reversed? Does the basis for reversal really cut either way on this question?

MS. PAYTON: I think it does cut, because the court was concerned about the level of interference of the district court in the decisions on the medical side.

And here -- *Wit* is a very complicated situation. And it was an ERISA case. But, you know, they were having experts testify and putting in all this evidence. It's very, very different. Here you have InterQual, right? And nobody is legitimately -- and Mr. King is not arguing that InterQual isn't a widely accepted industry standard. It's accepted by 70 percent of the hospitals and the providers.

THE COURT: I don't think that's in dispute.

MS. PAYTON: Yeah. So before you would go outside the administrative record and take a look at other criteria, which you could, if you were going to deviate from InterQual or find that InterQual was insufficient, I believe the court should make that finding, before extending outside of the administrative record.

THE COURT: Make what finding?

MS. PAYTON: That InterQual was insufficient. That the plan was using the wrong criteria. And there's just no basis to do that here.

THE COURT: Why do you have to make that finding to say that I can look at other criteria, too? I mean, basically, since this is de novo review, I can look at something that's generally accepted. It can be InterQual, or it could be something else.

MS. PAYTON: You can look at Milliman, it's on the Internet. You can find it. And I think it's in the public record, which you're allowed to look at.

And to your point, Your Honor, you actually have very specific evidence on medical necessity and industry standards, generally, in this very record. Because when you look at the course of this case, it has been looked at three times by a child adolescent psychologist, who looked not only at InterQual, but beyond, to the whole question of medical necessity. And the administrative story here really answers a lot of your questions. Because first it's looked at, if the claim isn't submitted until six months after the child has already been at the academy, it's looked at by a child and adolescent psychologist, who determines that it's not medically necessary, based on -- after a certain date -- based on the records that are before.

And in that communication, invites the family to appeal, if something has been missed, or there is something that they think additional that Premera should consider. They do. And that's when the mother writes that lengthy and very

thoughtful letter about all of the challenges, submits a number of letters from past providers, and some family friends, and really gives a lot of context about what's happening with the child.

Premera then sends it to an independent child and adolescent psychologist, outside of Premera, with all of that information, and with InterQual, and says: Decide this, based on industry standards and medical necessity.

That independent child psychologist determines it's not medically necessary, because the child isn't at the level of severity to require 24/7 monitoring by medical staff, and the provider isn't providing the medical services required under InterQual, which is intake by a psychologist within 24 hours, a treatment plan that is robust, a discharge plan, and that the child actually needs to see the doctor once a week, at a minimum, and have daily clinical analysis. And it is undisputed that that did not happen here.

And then invites the family, if they disagree with the decision on the Level 1 appeal, to go ahead and appeal again, with any new additions. They don't submit any new information, but they do appeal.

Premera sends it to a different independent child and adolescent psychologist, who determines that the care is not medically necessary, for the same reasons, that the child doesn't need 24/7 lockdown care.

And we have to remember in these cases, residential treatment is a level of severity which is very intense, in the life of a child, especially here for 14 months, when the child is taken away from the community, from home, from peers, from school. And to do that, we need to have a finding that the child needs that level of vigilance with 24/7 lockdown care.

Now, this family was entitled to go to the Insurance Commissioner for a state and federal mandated independent review, that is operated under the auspices of the State Insurance Commissioner in Washington. And in that process, the Insurance Commissioner will pick a reviewer, and have this looked at again.

Now, this family declined to do this. They didn't exhaust all the administrative remedies available, and instead chose to proceed with this court.

But this court has a robust amount of information in this administrative record, both through InterQual, and all of the reviews that have taken place. There's no question that this claim has received ample due process, and a lot of care and independent analyses to make sure -- to make sure, two things. One, that the right criteria was applied, that InterQual is correct; and that there was nothing else that needed to be looked at.

THE COURT: I'm still not understanding, though, why

I would have to find that it was improper to rely on InterQual, if I look at some other set of standards. Because the plan just says, you look at these standards -- defines them. And, sure, it's fine for Premera to look at InterQual. But now that it's a de novo review for the court, why can't I look at something else?

MS. PAYTON: You can look at additional things.

THE COURT: And that qualifies under the language of the plan?

MS. PAYTON: The language of the plan also says we will look at our medical policies that we have in place. And those medical policies were the InterQual criteria. And they were available, and they're on the website.

THE COURT: Isn't there something on the record that says that N.C. tried to access them and couldn't find them?

MS. PAYTON: There was a request for them, and they were cited extensively in the record. I believe they were produced. There's been no allegation that they didn't have them.

THE COURT: So I could look them up myself on the computer?

MS. PAYTON: Yes. You can go on to the Premera website and see them. They're also in the administrative record that is in front of you, in the review file.

THE COURT: You're not saying they're actually part

of the plan, are you?

MS. PAYTON: I'm not. That's a really interesting legal question that we don't have to get into here. The Honorable James Robart in the *Rust* case found that they were in part of the plan. Other courts have not. But there's certainly reference material.

Here's the thing about medical policies and InterQual. They're guidelines, right? Different humans have different needs, at different times, and they -- that's why multiple doctors look at these claims. And that's why we have a robust review process, to make sure that we are not making a mistake by just uniformly applying a set of criteria. But they are guidelines that are useful, and they can guide the thinking here. And there's no reason to think they were inappropriate in this case.

So I don't want -- I don't think the court needs to go so far as to say these were contractual terms that needed to be adhered to, because the truth is, we're looking at the totality of the situation. And under de novo review, you would want to do that to make sure that there was nothing amiss in how this claim -- because these claims are important, right? This is -- these are people's lives, and they need to have that robust review and analysis. And the medical guidelines are one part of that. But everybody is on notice, we're going to use InterQual. And nobody is arguing.

THE COURT: How are they on notice that you're going to use InterQual?

MS. PAYTON: So if you look in the policy, it says that we're going to review, based on medical policies. And those are the Premera medical policies that are available for members on the website.

THE COURT: So N.C., you're saying, would have been on notice that the InterQual guidelines would apply? Those specifically?

MS. PAYTON: Yes, Your Honor.

THE COURT: Where in the record is that?

MS. PAYTON: If you look at the first preauthorization -- when they first submit the claim, not preauthorization, the letter back from Premera has the InterQual guidelines cited, and I think provided to them, and they're citing from the exact language they are looking for. It also comes up in the Level 1 and 2. And we know the mother is on notice, because she talks at length about the InterQual criteria in her letter.

THE COURT: How about before that time? Is there any time before that, when she enters into the agreement, that she's told that these guidelines apply?

MS. PAYTON: Yeah. If you look on the website, there are hundreds and hundreds and hundreds of medical policies, right? And they could never be incorporated into the

contract. If you go to any carrier website, they'll have the medical policies available, if you want to look at any particular thing. You know, is there coverage for this type of treatment, or not? So they are available. But they're not in the contract itself, if I'm answering your question.

THE COURT: I think you did.

MS. PAYTON: Yeah. So they're a resource you can get, they're available, if you want. But, you know, there's no way that those hundreds and hundreds of medical policies would be something that you would send to a member. But they are available.

Like when you bind coverage and you wanted to look at, does this plan cover this certain type of thing, just in the same way you can see on the website who's in the network and who's not; or what are the visit limits and what's not. So those things are part of the plan, but not in the contract itself.

THE COURT: But you're not saying that N.C. assented to the terms of the InterQual guidelines, right?

MS. PAYTON: N.C. assented to the terms of the medical plan, and the medical plan definition of medical necessity. And there's no dispute that the InterQual criteria informs what "medical necessity" means, in the context of residential treatment centers.

THE COURT: I hear what you're saying. If we're on

the same page, I hear you saying that the plan has a standard for medical necessity, and the InterQual guidelines satisfy that standard.

MS. PAYTON: Correct. And you could go the path of the *Rust* case, which finds that they are incorporated into the plan. But I don't think you need to, because there really isn't a dispute, under any criteria, that this didn't give rise to that level of care. And, in fact --

THE COURT: Is there any case, besides the *Rust* case, that says there is such incorporation?

MS. PAYTON: No, not that I'm aware of. I think that when you look, there's a lot of residential treatment center cases. And we see the courts consistently looking at the medical policies as guidance, both in de novo or discretionary review, for what does medically necessary mean in this case.

And to the point of, you know, there are a few cases that find, boy, the medical policy was not right. And I can think of, like, the *Wit* case was one where the district court did that. But that's very rare. And I don't know of any case that rejects InterQual. I'm just not aware of it. Mr. King can tell me if there is one.

THE COURT: And, again, not making too fine a point, I'm not talking about rejecting InterQual, I'm talking about a court saying, okay, you applied InterQual, I'm going to

apply something else. Has that ever happened?

MS. PAYTON: No. I have not ever seen a case like that. No, I've seen the court say: Under InterQual, as well as -- but when they say the "as well as," it means they're looking at the review through the administrative process, because often the reviewers are not bound by any particular set of guidelines, they're using their professional judgment and they're going outside the medical policy.

But beyond that, no. But, you know, the main ones, as the court has pointed out, are Milliman and InterQual. And they're fairly similar. They don't really deviate too much. They're both going to require the salient issue here, which is: Do you have a doctor watching the child? Do you have a doctor look at the state of the child at intake, and make sure this child needs this level of confinement? And are you tracking the child, on a weekly basis, to make sure this child is still in the medical state to require these things? And if not, it's not medically necessary. The way that they're laid out is a little bit differently, but they really do come to the same result.

THE COURT: Can you turn to the Parity Act claim?

MS. PAYTON: Yeah.

THE COURT: Just a preliminary question. Does Premera use InterQual criteria to determine medical necessity in the inpatient hospice context?

MS. PAYTON: No, Your Honor. That's not in the record. So hospice is different. They both require that same level of care, with a doctor saying this is appropriate. But hospice is saying: This person is going to die. And that is a different analysis than under residential treatment where you do a very complex analysis of the child, because you want the child to get out of the residential treatment, and go on to have a productive life in the community.

THE COURT: You're saying this is apples and oranges?

MS. PAYTON: It is apples and oranges. And the regulators didn't identify inpatient hospice as an analogous treatment, because hospice is, in truth, where you go to die. And what we don't do is keep analyzing people, are you really dying. It's just not an appropriate role of the carrier here.

But it is appropriate with residential treatment to keep taking a look at, is this continued care necessary. The two analogous treatments are skilled nursing and rehabilitation. And interestingly, this plan, and including hospice, has more limitations on those medical-surgical interventions, because there are very specific limitations on the amount of time in those services than with the mental health treatment.

And you'll see that they really -- the Parity Act was designed to keep people from having more difficult access into the mental health treatment. And so what the regulation

says is, look at the processes by which you put the criteria in place. And one thing in the record that the plaintiff hasn't talked to you about is -- and it's at 6216 -- you'll see the parity analysis done on this plan. It is the parity analysis that is submitted to the state and federal regulators to show that a parity was occurring in this plan.

And one of the things that they look at is are you requiring a doctor to say that this level of treatment is necessary, or are you requiring a doctor to certify that this continued treatment -- that we're not keeping you here past the point -- and this is the big issue -- that you can't be treated safely and effectively at a lower level of care. Because we know that a lower level of care doesn't mean less care or worse care, it means appropriate care.

And all of these treatments have those same processes in place. There really isn't a legitimate argument that there is any differences here.

The Parity Act violations in residential treatment cases tend to arise -- they originally tended to arise where a plan would have skilled nursing, but no residential treatment available at all. That's not the case here. And, in fact, residential treatment is available on this plan, actually with no visitation limits at all.

There simply isn't a Parity Act claim here.

THE COURT: Is there any scenario under which there

would need to be a trial on any factual issue related to the Parity Act claim?

MS. PAYTON: No.

THE COURT: Do you remember when we talked about this at the status conference?

MS. PAYTON: I kind of remember. I think the parties have agreed that this is suitable for resolution on cross briefing, and nobody has raised any issue of material fact.

THE COURT: Did that agreement arise after that conference?

MS. PAYTON: I think we had already briefed it before, so I would say it was before, we put that position in place. But nobody has raised an objection.

THE COURT: I'll check with Mr. King. But my understanding is that at our status conference, you reserved the right to request a trial on issues relating to the Parity Act claim. So maybe he's withdrawing that. We'll see what his position is.

MS. PAYTON: We would have expected to hear this now, because we're now on a Rule 56 cross motion, where we have said to you that you can decide this issue as a matter of law. But more salient, I guess is, what question of fact? The entire record is in front of you. You have the NQTL, which is the analysis of the parity, in front of you. There really isn't anything else. You have the medical policies.

And you would have to find that -- from the record in front of you -- that there was some way that people were being discriminated against in the provision of the mental health treatment. And there simply are no facts in front of you to support that finding. And it would be novel, given the structure of this plan, and the state of this record.

So overall, Your Honor, I'm not sure how much time -- I haven't been --

THE COURT: You have about a minute.

MS. PAYTON: I'll sum up, then. Congress's intent with ERISA is clear, we want fast, efficient adjudication of claims, to make sure the people are getting the benefits to which they are entitled under ERISA. ERISA is comprehensive here, where it will take care of this member. Were you to find that there was something amiss in the way this claim was adjudicated, that member will be made whole, under ERISA.

There's no need for a parity claim here, because the only relief that the Parity Act can give is injunctive relief. And the only injunctive relief that these individuals would be entitled to, is the provision of benefits under the plan.

There is no ongoing claim that, I need this in the future. And there certainly is no class claim, that other people are entitled to relief. This is an individual action. So the plaintiffs are made whole by ERISA. Under the ERISA claim, there simply is not an issue of material fact that this claim

was adjudicated incorrectly. I don't think that plaintiffs disagree, that under the clear requirements in those InterQual guidelines, that this plaintiff was not receiving the level of care, or meeting the level of criteria required under the plan. And there is no dispute that this claim got ample due process. A lot of care. There was no infirmity in the way that it was done. It got an independent review, twice, by a child and adolescent psychologist. There is no reason to overturn this decision.

Thank you, Your Honor.

THE COURT: Thank you. Mr. King?

MR. KING: Thank you, Your Honor. I'll start kind of in reverse order with the mental health parity analysis. There was -- your question, Your Honor, was: What's the remedy? And I neglected to point out, I think the most obvious remedy is if you find that there is a violation of the Mental Health Parity Act, what you should do is strike those criteria that were used in denying the claim, send it back, remand it to Premera, and instruct them: You need to do analysis of whether those claims should be paid, without using the offending mental health parity criteria that created the disparity between the two.

So what we've had in other cases at times in the past, where the courts -- I'm thinking of some of our decisions from down in Utah -- are the court said, in their decision, I

find there's a mental health parity violation, but I also find it would be a futile gesture to remand it, because that's not going to result in payment of the claim.

That's something, however, in this case, that if you strike the offending mental health criteria that they use that violates the Mental Health Parity Act, you may very well find the claim would be paid on remand. So that is a remedy that's important. And that is the thing that creates standing, regardless -- you may say: I think you lose on the A(1)(b) claim, on the first cause of action, or denied benefit claim. But what we don't know is, if we struck from your consideration the criteria that violates the mental health parity claim, on remand, whether you would pay the claim or not. So that's definitely something that creates standing and a meaningful remedy.

Your Honor, there is a case -- well, let me talk about another aspect of the mental health parity claim. That is, the time limits for those skilled nursing facilities. Your Honor, MHPAEA, the mental health parity statute, is a one-way street. You can have more restrictive coverage limitations for a skilled nursing facility; that does not preclude more generous coverage for mental health and substance use disorders.

What Premera is saying is, well, we have a 14-day limit for skilled nursing facilities. So, sure, they can say it's

a 14-day limit for mental health and substance use disorders in a mental health treatment center. Not so.

What would be offensive to the statute is the reverse, where you have, as Ms. Payton indicated, a prohibition on coverage for residential treatment, with a 14-day limit for residential treatment, and unlimited coverage for skilled nursing facilities. So I think that's important for purposes of this court's analysis.

You asked, Your Honor, about issues of fact and whether we would want to have a trial. I think that we both do agree that there is sufficient information before the court to justify a ruling in each side's favor, of course, depending on who is arguing, in their favor.

However, I do think, Your Honor, that if there are questions in your mind about what generally accepted standards of medical practices are, for purposes of the mental health parity analysis, you could easily say, I think there are issues of material fact, we need a trial, I want to hear experts on this.

THE COURT: Now, but has that train not left the station? I mean, if that were the case, shouldn't the parties have engaged in expert discovery by this point?

MR. KING: Well, we have not done that, you're right, Your Honor, and that reflects the fact that we have, in our briefing, implicitly presented to you information on our

motions for summary judgment that allow you to say, we believe one side or the other side wins on this thing.

But if you say: I disagree with the underlying premise of both of you, I do think there are genuine issues of material fact, I need more information in order to evaluate this, I certainly think that that's within the court's discretion to do. It's not what we anticipate. But if that's what the court feels comfortable and necessary to be done to resolve the case, certainly I'm not going to object to that.

There is a case, Your Honor, that came down recently from Judge Parrish, and I'll send it to you. But let me give the cite to you. It came down a couple weeks ago. It deals with both benefit recovery and action and this denied benefits claim.

Theo M. v. Beacon Health Options, 2-19-CV364. District of Utah. The Lexis cite is 2022 U.S. Dist. LEXIS 177120. In that case, Judge Parrish finds that the application of acute care criteria is a violation of the terms of the plan, and justifies payment of benefits. Also talked about the MHPAEA claim, in passing. The court -- the decision wasn't on the mental health parity claim.

You know, Your Honor, I'm just about out of time. I don't want to miss something that you feel is important that we discuss. I'd be happy to answer any questions you have.

THE COURT: I think I'm good at this point. Are you

done with your presentation?

MR. KING: I am. Thank you.

THE COURT: Counsel, thank you very much for your presentations. I'll try to get you a ruling as soon as possible. And we'll be in recess.

(Adjourned.)

C E R T I F I C A T E

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

/s/ Debbie Zurn

DEBBIE ZURN
COURT REPORTER